45th day 5-10-19 — 70th day 6-4-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
Part 2	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

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F 000	INITIAL COMMENTS A recertification survey and complaint investigation #47163 were completed on 3/24/19 to 3/26/19 at Gallatin Health Care Center, LLC. No deficiencies were cited related to the complaint investigation under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, the facility failed to follow physician's orders related to wound care dressing change for 1 resident (#133) of 15 residents receiving wound care. The findings include: Facility policy review, Dressings, Dry/Clean, dated September 2013, revealed "...Verify that there is a physician's order for this procedure...Apply the ordered dressing...Label with date and initials to	F 686	Resident #133 wound was assessed by the RN and no changes noted. Resident #133 received wound care dressing change on 3/25/19 per physician order. All residents with physician orders for wound care dressing changes were audited for physician order compliance and appropriate action taken as needed. Wound care policy was reviewed and no changes needed. Licensed Nurses will be in-serviced by the Staff Development Coordinator (SDC)/designee on following physician orders for wound care dressing changes. Unit Managers will audit wound care dressing changes daily for three weeks then three times weekly for three weeks and once weekly thereafter. Audit results reported to DON. (continued on next page)	5/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla A. Cottrell, LNHA	Administrator	4/11/19

Received 4-22-19

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F 686	Continued From page 1 physician's order for this procedure...Apply the ordered dressing...Label with date and initials to top of dressing..." Medical record review revealed Resident #133 was admitted to the facility on 8/24/17 with diagnoses which included Diabetes Mellitus, Heart Failure, and Chronic Kidney Disease. Medical record review of the Order Summary Report dated January 2019 through March 2019 revealed "...clean with NS [normal saline] pat dry, pack wound with calcium alginate AG [silver], cover with bordered foam dressing every day shift and as needed if dressing becomes dislodged or soiled..." Observation of the wound care performed by Licensed Practical Nurse (LPN, wound care nurse) #4 for Resident #133, with the Wound Director present, on 3/25/19 at 12:32 PM in Resident #133's room, revealed the resident's wound dressing was dated 3/22/19. Interview with LPN #4 on 3/25/19 at 12:32 PM in Resident #133's room confirmed the wound dressing was dated 3/22/19. Interview with the Wound Director on 3/25/19 at 12:48 PM in the 100 Hallway confirmed Resident #133's wound dressing was dated 3/22/19 and the dressing was ordered to be changed daily. Interview with the Director of Nursing on 3/26/19 at 3:17 PM in her office confirmed she expected the nurses to follow physician's orders exactly how they are written.	F 686	(F686 continued) DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695	F695 on next page	4/18/19

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F 695 SS=D	Continued From page 2 CFR(s): 483.25(i)	F 695		

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on the medical record review, observation and interview, the facility failed to provide necessary respiratory care for residents 2 (#24 and #482) of 37 residents receiving respiratory services.

The findings include:

Medical record review revealed Resident #24 was admitted to the facility on 2/25/19 with diagnoses which included Seizures, Tracheotomy, Malignant Neoplasm of Trachea, and Panic Disorder.

Medical record review of Resident #24's physician order dated 2/25/19 revealed "...Change nebulizer mask and tubing weekly; date and place in dated plastic bag (Sun. night). Place in dated bag when not in use ..."

Medical record review of the Care Plan dated 2/25/19 revealed "...has tracheostomy r/t [related to] history of laryngeal cancer..."

Medical record review of the Care Plan dated 3/1/19 to 3/26/19 revealed " ...at risk for altered breathing pattern r/t [related to] congestion, use

(F695 continued)
Resident #24 was given a new nebulizer and tubing which was bagged and dated on 3/26/19.
Resident #482's BiPap mask was cleaned and given new tubing, and nasal cannula oxygen tubing which were bagged and dated on 3/26/19.
All resident's receiving respiratory care were audited for proper bagging and dating of respiratory tubing and supplies.
Policy on proper storage of respiratory supplies was reviewed and no changes needed. Nurses, nurse aides, therapists (rehab & RT) and Activity aides were in-serviced on proper bagging and dating of respiratory tubing and supplies.
Unit Managers will audit residents receiving respiratory care daily for three weeks then three times weekly for three weeks and once weekly thereafter. Audit results will be reported to DON.
DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance.

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F 695	Continued From page 3 of supplemental oxygen, Pneumonia ..." Observation of Resident #24 in the residents room on 3/24/19 at 9:10 AM and again at 11:35 AM revealed the Nebulizer and tubing lying on the bedside stand unbagged and undated. Medical record review revealed Resident #482 was admitted to the facility on 3/15/19 with diagnoses which included Acute and Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, and Pulmonary Hypertension. Observation of Resident #482 in the residents room on 3/24/19 at 9:45 AM and again at 3:17 PM revealed the Bilevel Positive Airway Pressure mask (BiPAP) and tubing drapped over the bedside stand unbagged and undated. Further observation on 3/24/19 at 12:39 PM revealed nasal cannual oxygen tubing on the floor. Interview with Licensed Practical Nurse #9 on 3/24/19 at 3:18 PM in Resident #24's room and Resident #482's room confirmed "... that the nebulizer and tubing needed to be in the bag when not in use..."	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 726	Resident #100's wound was correctly staged and was verified on 3/26/19 by the RN. All residents with wounds were audited for correct staging and action taken as needed. (continued on next page)	5/1/19

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F 726	Continued From page 4 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on the medical record review, observation, and interview, the facility failed to ensure nursing staff have the knowledge and competencies, and skill sets for staging pressure ulcer 1 resident (#100) of 15 residents with staging pressure ulcers. The findings include: Review of the Medical record revealed Resident #100 was admitted to the facility on 1/11/19 with diagnoses which included Pressure Ulcer of Other Site, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Contracture of Muscle Right Lower Leg, and Peripheral Vascular Disease.	F 726	(F726 continued) Policy on wound staging was reviewed and no change needed. Licensed Nurses were in-serviced on correct staging of wounds by the Staff Development coordinator (SDC)/designee and competencies will be completed on all licensed nurses. SDC/designee will audit wounds for correct staging and monitor for changes for three weeks then three times weekly for three weeks and once weekly thereafter. Audit results reported to DON. DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance.	

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F 726	Continued From page 5 Medical record review of the Wound Admission Assessment dated 1/11/19 revealed "... unstageable to bilateral heels, golf size black/purple areas bilaterally...". Medical record review of the of the Weekly Wound Report dated 1/16/19 revealed "...suspected deep tissue injury of bilateral heels..." Interview with the Regional Wound Care Consultant on 3/26/19 at 4:30 PMin the Director of Nursing office revealed, the wound assessment dated 1/11/19 was "... inaccurate..." Continued interview revealed the wound was a "... deep tissue injury as described on 1/16/19..." Interview with the Regional Wound Care Consultant and Director of Nursing (DON) on 3/26/19 at 5:30 PM and 6:30 PM, respectfully, in the DON's office confirmed wound competencies on the staging of pressue ulcers with the nursing staff have not been done.	F 726		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 756	Resident #121 received an appropriate, 14 day, stop date on the anti-psychotic medication on 3/26/19. All residents on an as needed (PRN) anti-psychotic/psychotropic medications were audited for appropriate stop date and action taken as needed. (continued on next page)	5/1/19

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F 756	Continued From page 6	F 756		

and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, medical record review and interview the pharmacist failed to make recommendations for a stop date related to a prn (as needed) anti-psychotic medication for 1 resident (#121) of 32 residents reviewed receiving anti-psychotic medications.

The findings include:

Review of the undated facility policy, Psychotropic Medication, revealed "...Psychotropic medications

(F756 continued)

Policy was reviewed and no revisions needed. Licensed nurses will be in-serviced by the SDC/designee to include appropriate stop date on orders for PRN anti-psychotic medication orders.
Nurses will be in-serviced on providing an adequate diagnosis and stop date for psychotropic/antipsychotic medications. Unit Managers will audit new orders for anti-psychotic medications for adequate diagnosis and appropriate stop date and report results to DON weekly.
DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance.

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F 756	Continued From page 7	F 756		

include any drug that affects brain activities associated with mental processes and behavior, including: anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs. Physicians and physician-extenders (Ex. Physician Assistant, Nurse Practitioner) will use psychotropic medications appropriately, working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring...An appropriate diagnosis will be documented in the medical record...The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident...Efforts to reduce dosage or discontinue of psychopharmacological medications will be ongoing as appropriate for the clinical situation...Findings including continued need will be documented in the medical record...PRN (as needed) orders for psychotropic medications ate limited to 14 days unless the primary care provider reviews, evaluates and documents the rationale for extension...Documents rational and diagnosis for use and identifies target symptoms...Evaluates with the interdisciplinary team, effects and side effects of psychoactive medications within 14 days of initiation, increasing, or decreasing dose and during routine visits thereafter...Orders for PRN psychotropic medications will be time limited to 14 days and only for specific clearly documented circumstances...Monitors psychotropic drug use daily, noting any adverse effects such as increased somnolence or functional decline..."

Medical record review revealed Resident #121

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F 756	Continued From page 8	F 756		

was admitted to the facility admitted on 10/1/18 and readmitted on 12/17/18 with diagnoses which included Generalized Anxiety Disorder, Unspecified Psychosis and Major Depressive Disorder. Continued review revealed the resident was admitted to hospice services on 2/1/19.

Medical record review of Resident #121's physician order dated 1/28/19 revealed "...Haloperidol Lactate Concentrate [an antipsychotic drug used to treat certain types of mental disorders, trade name Haldol] 2 milligrams per milliliter [mg/ml] give 1 mg by mouth every 3 hours as needed for agitation for 90 days or sublingual...end date 4/28/19..."

Medical record review of Resident #121's Order Summary Report dated January through March 2019 revealed no psychotropic drug side effect or behavior monitoring in place for the haloperidol.

Medical record review of Resident #121's Medication Administration Record for January, February and March 2019 revealed there were no psychotropic side effect or behavior monitoring in place.

Medical record review of Resident #121's monthly drug regimen reviews performed by the pharmacist dated 10/3/18, 10/29/18, 11/28/18, 12/19/18, 1/29/19 and 2/24/19 revealed "...The medication regimen of the resident was reviewed, and there were no apparent irregularities noted..."

Interview with the Director of Nursing on 3/26/19 at 3:11 PM in her office when asked to look at Resident #121's physicians orders confirmed the resident did not have a 14 day stop date for haloperidol. Continued interview confirmed the

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F 756	Continued From page 9 pharmacist evaluates each resident's medications monthly and sends the facility a report of the recommendations. Telephone interview with the Pharmacist on 3/26/19 at 4:07 PM and at 5:25 PM confirmed "when a resident has a prn antipsychotic/psychotropic drug ordered, it is limited to 14 days and the resident has to be reevaluated by the physician to extend the prn 14 day stop date." Continued interview when asked about pharmacy recommendations for Resident #121 she stated "if she [Resident #121] had an order for Haldol prn for 90 days, I would have given a recommendation for her to be re-evaluated by the physician and there is no exception for hospice." Continued interview confirmed "the facility records are correct, I did not leave a recommendation for the Haldol for the resident [Resident #121]."	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757	Resident #121 has a psychotropic/antipsychotic drug side effect and behavior monitoring placed on 3/27/19. All residents on anti-psychotic/psychotropic medications were audited for side effect /behavior monitoring and action taken as needed. (continued on next page)	5/1/19

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F 757	Continued From page 10 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview the facility failed to have psychotropic/antipsychotic drug side effect or behavior monitoring in place for 1 resident (#121) of 32 residents reviewed receiving anti-psychotic medications. The findings include: Review of the undated facility policy, Psychotropic Medication, revealed "...Psychotropic medications include any drug that affects brain activities associated with mental processes and behavior, including: anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs. Physicians and physician-extenders (Ex. Physician Assistant, Nurse Practitioner) will use psychotropic medications appropriately, working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring...An appropriate diagnosis will be documented in the medical record...The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident...Efforts to reduce dosage or discontinue of psychopharmacological medications will be ongoing as appropriate for the	F 757	(F757 continued) Policy on psychotropic medication was reviewed and no revisions needed. Licensed Nurses will be in-serviced by the SDC/designee on providing side effect and behavior monitoring for psychotropic/antipsychotic medications. Unit Managers will audit new orders for anti-psychotic medications for adequate diagnosis and appropriate stop date and report results to DON weekly. DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance.	

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F 757	Continued From page 11	F 757		

clinical situation...Findings including continued need will be documented in the medical record ..PRN (as needed) orders for psychotropic medications are limited to 14 days unless the primary care provider reviews, evaluates and documents the rationale for extension. Documents rational and diagnosis for use and identifies target symptoms...Evaluates with the interdisciplinary team, effects and side effects of psychoactive medications within 14 days of initiation, increasing, or decreasing dose and during routine visits thereafter...Orders for PRN psychotropic medications will be time limited to 14 days and only for specific clearly documented circumstances...Monitors psychotropic drug use daily, noting any adverse effects such as increased somnolence or functional decline..."

Medical record review revealed Resident #121 was admitted to the facility on 10/1/18 and readmitted on 12/17/18 with diagnoses which included Generalized Anxiety Disorder, Unspecified Psychosis and Major Depressive Disorder. Continued review revealed the resident was admitted to hospice services on 2/1/19.

Medical record review of Resident #121's physician order dated 1/28/19 revealed ". Haloperidol [trade name Haldol] Lactate Concentrate [an antipsychotic drug used to treat certain types of mental disorders] 2 milligrams per milliliter [mg/ml] give 1 mg by mouth every 3 hours as needed for agitation for 90 days or sublingual...end date 4/28/19..."

Medical record review of Resident #121's Order Summary Report dated January thru March 2019 revealed there were no psychotropic drug or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 12 behavior monitoring in place for haloperidol. Medical record review of Resident #121's Medication Administration Record for January, February and March 2019 revealed there were no psychotropic side effect or behavior monitoring in place. Medical record review of Resident #121's monthly drug regimen reviews performed by the pharmacist dated 10/3/18, 10/29/18, 11/28/18, 12/19/18, 1/29/19 and 2/24/19 revealed "...The medication regimen of the resident was reviewed, and there were no apparent irregularities noted..." Telephone interview with Resident #121's Hospice Physician on 3/26/19 at 12:18 PM confirmed "side effect monitoring is a team effort between hospice and the facility and side effects should be monitored and documented." Interview with the Director of Nursing on 3/26/19 at 3:11 PM in her office when asked to look at Resident #121's physicians orders confirmed the resident did not have any psychotropic side effect or behavior monitoring in place.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758	Resident #121 had an adequate diagnosis and stop date placed for psychotropic/antipsychotic medication placed on 3/27/19. (continued on next page)	5/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 13 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758	(F758 continued) All residents on anti-psychotic/psychotropic medications were audited for adequate diagnosis and stop date placed for psychotropic/antipsychotic medication and action taken as needed. Licensed Nurses will be in-serviced on providing an adequate diagnosis and stop date for PRN psychotropic/antipsychotic medications. Unit Managers will audit new orders for anti-psychotic medications for adequate diagnosis and appropriate stop date daily for three months. Any discrepancies will be reported to the DON for appropriate follow up. DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

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F 758	Continued From page 14 Based on facility policy review, medical record review and interview the facility failed to provide an adequate diagnosis and a 14 day stop date for a prn (as needed) anti-psychotic drug for 1 resident (#121) of 32 residents reviewed receiving anti-psychotic medications. The findings include: Review of the undated facility policy, Psychotropic Medication, revealed "...Psychotropic medications include any drug that affects brain activities associated with mental processes and behavior, including: anti-anxiety/hypnotic, antipsychotic and antidepressant classes of drugs. Physicians and physician-extenders (Ex. Physician Assistant, Nurse Practitioner) will use psychotropic medications appropriately, working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring . An appropriate diagnosis will be documented in the medical record...The facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized to meet the needs of the individual resident...Efforts to reduce dosage or discontinue of psychopharmacological medications will be ongoing as appropriate for the clinical situation...Findings, including continued need will be documented in the medical record...PRN (as needed) orders for psychotropic medications are limited to 14 days unless the primary care provider reviews, evaluates and documents the rationale for extension ..Documents rational and diagnosis for use and identifies target symptoms...Evaluates with the interdisciplinary team, effects and side	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 15	F 758		

effects of psychoactive medications within 14 days of initiation, increasing, or decreasing dose and during routine visits thereafter...Orders for PRN psychotropic medications will be time limited to 14 days and only for specific clearly documented circumstances...Monitors psychotropic drug use daily, noting any adverse effects such as increased somnolence or functional decline..."

Medical record review revealed Resident #121 was admitted to the facility on 10/1/18 and readmitted on 12/17/18 with diagnoses which included Generalized Anxiety Disorder, Unspecified Psychosis and Major Depressive Disorder. Continued review revealed the resident was admitted to hospice services on 2/1/19.

Medical record review of Resident #121's physician order dated 1/28/19 revealed "...Haloperidol Lactate Concentrate [an antipsychotic drug used to treat certain types of mental disorders, trade name Haldol] 2 milligrams per milliliter [mg/ml] give 1 mg by mouth every 3 hours as needed for agitation for 90 days or sublingual...end date 4/28/19..."

Medical record review of Resident #121's monthly drug regimen reviews performed by the pharmacist dated 10/3/18, 10/29/18, 11/28/18, 12/19/18, 1/29/19 and 2/24/19 revealed "...The medication regimen of the resident was reviewed, and there were no apparent irregularities noted..."

Telephone interview with Resident #121's Hospice Physician on 3/26/19 at 12:18 PM confirmed she was aware of the 14 day stop date for psychotropic medications and stated "with hospice patients we have prn (as needed) haldol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 16 for psychosis and terminal agitation." Continued interview when asked if agitation was a correct diagnosis for haldol (haloperidol) she stated "no, it should be psychosis or terminal agitation." Continued interview confirmed she stated "side effect monitoring is a team effort between hospice and the facility and side effects should be monitored and documented." Interview with the Director of Nursing on 3/26/19 at 3:11 PM in her office when asked to look at Resident #121's physicians orders confirmed the resident did not have a 14 day stop date for the prn haloperidol. Continued interview when asked to look at the resident's diagnosis for the haloperidol confirmed there was not an appropriate diagnosis used for the drug use. Continued interview confirmed "the resident has to be reevaluated by the physician to extend the 14 day stop date for a prn anti-psychotic." Continued interview when asked if Resident #121 was re-evaluated by the physician to extend the prn medication stop date she stated "no."	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761	The Optimum Bacillus, Acetaminophen 500mg 100 count bottle, Aspirin 325mg 100 count bottle, Mylanta 355ml bottle, tube of Preparation H and 1 intravenous catheter adapter were removed from medication cart 300B. (continued on next page)	5/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 761 Continued From page 17

biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, observation, and interview, the facility failed to refrigerate and properly store medications on 4 of 12 medication carts.

The findings include:

Review of facility policy, Administering Medications, dated 2001, revised December 2012, revealed "...When opening a multi-dose container, the date opened shall be recorded on the container...Staff shall follow established facility infection control procedures for the administration of medications..."

Review of facility policy, Storage of Medications, dated 2001, revised April 2007, revealed "...Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received...The nursing staff shall be responsible for maintaining medication storage AND preparation areas. .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals...Drugs for external use, as well as

F 761 (F761 continued)

The following were removed from medication cart 100A: Mucinex 400mg, Lactulose solution 10mg/ml, Dakins solution, multi-dose bottle of Valporic acid and a Bisacodyl suppository. The following were removed from medication cart 200B: bottle of Biscodyl 5mg tabs 150 count, and albuterol ampoules. The following were removed from medication cart 400B: FirVanq suspension 25mg/ml, 10 albuterol ampoules, Nystop powder, tubes of Skin repair & Medihoney, open box of 16 skin prep pads, oral medication administration supplies, gastric tube feeding supplies, stoma supplies and Skin Repair ointment.
.All medication carts have the potential to be effected by this practice and were audited for proper storage and labeling of medications, biological and supplies, with action taken as needed.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18 poisons, shall be clearly marked as such, and shall be stored separately from other medications...Medications requiring refrigeration must be stored in a refrigerator..." Observation of the 300B medication cart on 3/25/19 at 5:20 PM in the hallway with Licensed Practical Nurse (LPN) #1revealed the following: a multiple dose bottle of Optimum Lacto Bacillus (a medication used for the restoration of normal intestinal bacteria after antibiotic use) opened and not dated; a multiple dose bottle of Acetaminophen (a medication used for pain or fever) 325 milligram (mg) 100 count bottle opened and not dated; a multiple dose bottle of Acetaminophen 500 mg 100 count bottle opened and not dated; a multiple dose bottle of Aspirin (a medication given for pain, fever, or as an anticoagulant) 325 mg 100 count bottle opened and not dated; a multiple dose bottle of Mylanta (a liquid medication used for upset stomach) 355 milliliters (ml) opened not dated; 1 tube of Preparation H (an ointment used for relief of Hemorrhoids) opened, not dated and not labeled with a resident identifier. Continued observation revealed 1 intravenous (IV) catheter adapter dated 9/2016, expired. Observation of the 100A medication cart on 3/25/19 at 5:45 PM in the hallway with LPN #5 revealed the following: a multiple dose bottle of Mucinex (a medication used to thin mucous secretions) 400 mg opened and not dated; a multiple dose bottle of Lactulose solution (a liquid medication used for constipation) 10 milligram per milliliter (mg/ml) opened and not dated; a multiple dose bottle of Dakins solution (a liquid medication used to irrigate wounds) opened and not dated; a multiple dose bottle of Valporic acid	F 761	(F761 continued) The policy for storage of Medications was reviewed by the Director of Nursing (DON) and no revisions were needed. Licensed Nurses will be in-serviced by the SDC/designee on proper storage and labeling of medications, biological and supplies. Unit managers or designees will conduct audits of medication carts twice weekly for three weeks then weekly for three weeks then once every other week and report results to the DON weekly. The DON will report results to the QA/QAPI Committee monthly until QA/QAPI Committee deems compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 19	F 761		

(a medication used for treating seizures) opened and not dated; and a Bisacodyl suppository (a stimulant/laxative) not labeled with a resident identifier, and not stored in the original container.

Observation of the 200B medication cart on 3/26/19 at 2:30 PM in the 200B nurses station with LPN #7 revealed the following: a multiple dose bottle of Bisacodyl 5 mg tablets 150 count opened with expiration date 10/18/18; 4 Albuterol ampules (used for inhalation treatment for asthma, emphysema, and other lung diseases) not stored in their original protective foil package, and undated.

Observation of the 400B medication cart on 3/26/19 at 3.00 PM in the hallway with LPN #8 revealed the following: a FirVanq suspension (an oral form of the antibiotic Vancomycin used to treat infections) 25 mg/ml 150 ml bottle unrefrigerated and at room temperature; 2 individually packaged Keppra (a medication for seizures) capsules loose in drawer unlabeled; 10 Albuterol ampules not in their original protective foil package, and undated; Nystop powder (a topical used for fungal rashes) undated and unlabeled; a tube of Vit A&D ointment, a tube of Skin Protective ointment, a tube of Skin Repair ointment, and a tube of Medihoney ointment (all 4 topicals used for prevention and treatment of rashes) open, unlabeled and undated; an open box of 16 individually packaged skin prep pads (used to prepare the skin for a procedure) expired; and oral medication administration supplies, gastric tube feeding supplies, stoma supplies, and 2 open ointments, Skin Protective ointment and Skin Repair ointment (typically used for topical use around stoma openings or in the genital area) stored in the same drawer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

A4 ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(A5) COMPLETION DATE
F 761	Continued From page 20 Interview with the Director of Nursing on 3/26/19 at 6:16 PM in her office confirmed "...medications should be stored appropriately on all med carts..."	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	All ice scoops on mobile carts containing ice were placed in temporary sanitary containers on 3/26/19. New "clamshell" ice scoop containers have been ordered and will be placed on all mobile carts containing ice. All staff will be in-serviced on sanitary usage and storage of ice scoops. Resident #146 was counseled regarding asking staff for assistance in obtaining ice versus independent appropriation. Unit Managers or designees will conduct daily random audits of ice scoop storage on mobile carts during tray pass and report results to DON weekly. DON will report audit results to Quality Assurance Committee / Quality Assurance Performance Improvement Committee monthly for three months or until QA/QAPI Committee deems compliance.	5/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, medical record review, observation and interview the facility failed to maintain ice storage container and scoop in a sanitary manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

The findings include:

Review of the facility's policy, Ice Machines and Ice Storage chest, revised January 2012, revealed "...Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice ...Ice making machines, ice storage chests/containers, and ice can all become contaminated by: Unsanitary manipulation by employees, residents, and visitors; Improper storage or handle of ice...To prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: Limit access to ice machines or ice storage chests/containers to employees only; Do not handle ice directly by hand; Keep the ice scoop/bin in a covered container when not in use ."

Medical record review revealed Resident #146 was admitted to the facility on 4/13/18 with diagnoses which included Vascular Dementia, Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome and Generalized Anxiety Disorder.

Medical record review of Resident #146's quarterly Minimum Data Set dated 12/18/18 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating the resident was moderately cognitively impaired.

Observation on 3/25/19 at 8:30 AM on the 200 hall revealed an unattended ice storage container cart with an empty clear plastic bag sitting on the top of the cart. Continued observation revealed no ice scoop placed in the plastic bag or on top of the cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION	(X4) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

Observations on 3/25/19 at 8:55 AM and 10:18 AM on the 200 hall revealed Resident #146 walked up to the unattended ice cart and took the top off of her water pitcher and placed it on top of the cart. Continued observation revealed the resident opened the lid of the ice chest, reached into the chest with her bare hands obtaining the ice scoop from inside the chest. Continued observation revealed the resident filled her cup with ice, replaced the ice scoop back into the ice chest and closed the lid.

Interview with Resident #146 on 3/25/19 at 8:55 AM on the 200 hall by the ice storage cart revealed when asked if she got ice from that container she stated "I always get my own ice with the scooper, I never touch the ice just the scooper and then I put the scooper back in the container."

Interview with the Director of Nursing on 3/25/19 at 10:43 AM on the 200 hall by the ice storage cart confirmed the ice scoop was to be stored in a bag and not in the ice chest. Continued interview when asked the process of passing ice confirmed "the CNA's (Certified Nurse Aides) use the cart to pass ice, they are supposed to pass the ice and remove the cart from the hall; Residents should not be getting ice out of it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. BUILDING _____ B. WING _____	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE CENTER, LLC	438 NORTH WATER AVE GALLATIN, TN 37066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		

An emergency preparedness survey was completed on 3/24/19 to 3/26/19 at Gallatin Health Care Center, LLC. No deficiencies were cited under FED-E-1.00.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation